

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

JUN 12 1937

**791
1003**

File No. **18162**
Registered No. **4738**

1. PLACE OF DEATH
County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis Mo. (No. Barnes, Hospital) St. _____ Ward _____

2. FULL NAME Neeham Henry Tabacnic
(a) Residence, No. Marion Roe Hotel St. 25 Ward _____
(Usual place of abode) 508 Pine St. (If nonresident, give city or town and State)
Length of residence in city or town where death occurred _____ yrs. mos. ds. How long in U. S., if of foreign birth? _____ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lucille Tabacnic
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 21, 1892
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
45 0 18
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Salesman
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Life & Acc. Ins.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9th 1937
22. I HEREBY CERTIFY, That I attended deceased from May 8th, 1937 to May 9th, 1937
I last saw him alive on May 9th, 1937. Death is said to have occurred on the date stated above, at 12.30 A.M.
The principal cause of death and related causes of importance were as follows:

Cerebrospinal meningitis
non epidemic
Date of onset 5/9/37
Other contributory causes of importance: W

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cincinnati Ohio
13. NAME Aaron Tabacnic
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland
15. MAIDEN NAME Elizabeth Boonshaft
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Poland
17. INFORMANT Lucille Tabacnic
(ADDRESS) Marion Roe Hotel
18. BURIAL, CREMATION, OR REMOVAL PLACE Chesed Shel Emeth DATE 5/10/37

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? yes
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

19. UNDERTAKER H. B. Berger & Co.
(ADDRESS) 4715 Maryland
20. FILED J. J. Bredeck
19____ Registrar.

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Reverell, M. D.
(Address) _____

MAY 10 1937

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

55 CHICAGO HALL

CHICAGO, ILLINOIS 60637

TEL: 773-936-3500

FAX: 773-936-3500

WWW: WWW.PHYSICS.UCHICAGO.EDU

WWW: WWW.PHYSICS.UCHICAGO.EDU